PHYSICAL THERAPY BOARD OF CALIFORNIA

AUTHORIZATION FOR RELEASE OF MEDICAL, PHYSICAL THERAPY, ALCOHOL, OR DRUG ABUSE PATIENT RECORDS

Patient Name:_____ Date of Birth:_____

I, the undersigned hereby authorize the listed facilities to disclose records in the course of my treatment, to include medical, physical therapy, alcohol and drug abuse records (Please include the full name and address of the physical therapist and/or physical therapist assistant, and other health care providers/hospitals, which may have been involved in the care).

(1) _____ (3) _____

_____ _____

_____ _____

(2) _____ (4) _____

_____ _____

_____ _____

The records should be disclosed to:

PHYSICAL THERAPY BOARD OF CALIFORNIA
1418 HOWE AVENUE, SUITE 16
SACRAMENTO, CA 95825-3204

Or its designated agent of the Physical Therapy Board of California

This disclosure of records authorized herein is required for official use including investigation and possible proceedings regarding any violations of the laws of the State of California.

This authorization shall remain valid until the Physical Therapy Board of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have to the right to receive a copy of this authorization if requested by me.

Signature:_____
(Patient) (Date)

Or:_____
(Legal Representative) (Relationship) (Date)